New Hampshire Department of Safety
Bureau of Emergency Medical Services

Instructions for Completing the Automated External Defibrillation (AED) Incident Report & Quality Improvement Form

Listed below are instructions intended to assist you while completing the AED Quality Improvement Form. The line numbers on this form correspond with the line numbers on the AED Quality Improvement Form. If you have any questions or need further assistance completing the form, please contact the NH Bureau of EMS at (603) 271-4568 or 1-888-827-5367.

Line 1	List the name of the entity providing the AED program.
Line 2	List the name of person who used the AED on the patient.
Line 3	Indicate the date and time the AED was used on the patient. For the date, indicate the month, day and year. For the time, indicate the hour and minutes of when the incident occurred.
Line 4	Indicate the patient's age and place a checkmark next to the patient's gender.

Line 5	Asking whether CPR was administered prior to use of the AED. Check whether CPR was attempted or not attempted.
Line 6	Check whether the patient's cardiac arrest was not witnessed, was witnessed by a bystander or was witnessed by the person who used the AED on the patient.
Line 7	Indicate the estimated number of minutes from the patient's cardiac arrest to when CPR was administered.
Line 8	Check whether shock was indicated or not indicated by the AED.
Line 9	Indicate the estimated number of minutes from the patient's cardiac arrest to the first shock from the AED. Also indicate the number of shocks given to the patient.
Line 10	Check the description(s) that best describes the patient after the use of the AED.

Line 11	List the name of the ambulance service that treated the patient and transported the patient to a hospital/medical facility.
Line 12	List the name of the hospital or other medical facility the patient was transferred to by the ambulance.
Line 13	List the name of the physician authorizing use of the AED program for your organization and providing Quality Assurance oversight.

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This form is to be completed by the entity's AED Program representative or the AED user. Once completed, send a copy of this report to the NH Bureau of EMS at 33 Hazen Drive, Concord, NH 03305.

Line 1	Name of Entity Providing AED_____
Line 2	Name of AED Operator_____
Line 3	Date of Incident_____/_____/_____ Time of Incident_____:_____
Line 4	Patients Age_____ Patient's Gender(☐) Male (☐) Female

Line 5	CPR Prior to Defibrillation? (☐) Attempted (☐) Not Attempted
Line 6	Cardiac Arrest: (☐) Not Witnessed (☐) Witnessed by Bystander (☐) Witnessed by AED Provider
Line 7	Estimated Time (in minutes) From Arrest To CPR____:____
Line 8	Shock: (☐) Indicated (☐) Not Indicated
Line 9	Estimated Time (in minutes) From Arrest to First Shock:____:____ Number of Shocks:_____
Line 10	Patient Outcome at Incident Site: (check all that apply) (☐) Return of Pulse and Breathing (☐) No Return of Pulse or Breathing (☐) Return of Pulse with No Breathing (☐) Became Responsive (☐) Return of Pulse, Then Loss of Pulse (☐) Remained Unresponsive

Line 11	Name of Transporting Ambulance_____
Line 12	Name of Facility Patient Transported To_____
Line 13	Name of Physician Authorizing Use of AED_____

Signature of AED Provider_____Date_____